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ABSTRACT

This essay examines ethical considerations in the nurse patient relationship, in particular the relationship between "professional morality" and the nurse's professional identity in the role of advocate for doctors, patients, and hospitals. A discussion of ethics and professionals explores professional ethics, the need for such ethics, and their expression in licensing and certification, where it is recognized that consumer interests are primary. The paper then expands on the notion of the nurse as professional and the definition of consumer protection interests. This section examines the four quintessential ethical duties that nurses owe their clients: autonomy, nonmalfeasance, beneficence, and justice; discusses the conflicts in the "right-to-die" movement; and lists solutions to ethical dilemmas. The following section explores three models by which nurses construe their professional relationships with patients: the nurse bureaucrat or hospital advocate, the nurse as physician advocate, and the nurse as patient advocate. The essay goes on to present an argument for the moral superiority of the nurse patient advocate model based on the importance of informed consent and nurses' frequent encounters with informed consent. A final section examines nursing curricula in light of the nurse as patient advocate model. Included are 14 references. (JB)

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IMPLICATIONS FOR NURSE EDUCATION PROGRAMS

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The Nurse As Patient Advocate: Implications for Nurse Education Programs

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Introduction

Biomedical moral or ethical dilemmas, especially in nursing, inevitably focus on the ethical repercussions of professional relationships, and for good reason. Questions over the rights and duties that occur between the health provider and consumer, which are qualified by their relationship, constantly lead to debate over just which party in the relationship ought to prevail on deciding what is "good," right," or "just" (Francoeur, 1983; Pence, 1990).

This paper examines certain ethical considerations in the nurse-patient relationship. I will begin by discussing the relationship between "professional morality" and the nurse's professional identity in the role of hospital advocate, physician advocate, or patient advocate. I will then illustrate how the duty to secure informed consent complements and clarifies certain aspects of the nurse/patient advocate. I will conclude by posing a series of considerations on how nursing education might respond to these findings and observations.

Ethics and Professionals

A good place to begin an inquiry on the moral nature of health care relationships is with professional ethics. Because nurses and most other health providers unproblematically qualify as "professionals," questions examining the moral trappings of professionalism provide a convenient starting point for a discussion of the specifics of the nurse-patient relationship.

What does it mean to be a professional?

What is the moral relationship between the professional and society?

What are the primary ethical responsibilities that all professionals assume by virtue of their callings as professionals?

First of all, we must recognize that authentic professional groups arise in response to social needs. As Bayles (1981) has explained, society identifies a need for services whose delivery requires a sophisticated degree of skill and competence that is only acquired through considerable practice and learning. Thus, professional groups evolve as bodies of learned individuals whose principal function is to exercise their skills to protect society or advance its welfare.

By requiring its professionals to be licensed or certified, society protects them from infiltration by the unskilled or untrained. Although professionals often view licensure or certification processes as an onerous or burdensome rite of passage, they are intended to insure that consumers of professional services are not placed at unreasonable risk of harm by being exposed to unqualified people. The professional licensure or certification, then, is a social imprimatur that bestows upon its bearers the right to practice their skills to benefit society's members.

An immoral professional, then, is one who subordinates the interests or welfare of consumers to the interests of some other party. Thus, professionals cease being ethical when they jeopardize the welfare of the public through fraud, misrepresentation, or producing poor quality or dangerous products or services. In such instances, the good of consumers cannot be advanced, since the

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"professional" has posited his or her own good and welfare as the primary objective or failed to take adequate or reasonable steps to insure the safety of potential clients. A host of protective measures--ranging from mandating continuing education for professionals, to maintaining agencies that monitor professional compliance with regulatory policies, to threatening litigation or licensure revocation for gross immorality or negligence--exist to discourage unprofessional practices.

. . . the ethical gravity of professionalism recognizes that consumer interests are primary.

In brief, the ethical gravity of professionalism recognizes that consumer interests are primary. Examples of professional conduct that depart from the interest of consumers' welfare must show minimally that such departure does not unduly jeopardize or imperil consumers. Furthermore, professional ethics cannot ignore how consumers define "benefits," "goodness," or "rightness," since those definitions are crucial in contrasting professional conduct from misconduct.

The Nurse As Professional: What Are the Consumer Protection Interests?

GUIDELINES

Nurse as Consumer Advocate

AUTONOMY, meaning the right of a patient to be self-determining and to participate in decisions over his or her welfare, even to the extent of refusing unwanted treatment; correlatively, autonomy means the health professional has a duty to respect a patient's right to be free from coercion and manipulation and to respect the patient's right to determine what shall count as benefits and burdens while undergoing care.

NONMALEFICENCE, meaning the right of persons not be harmed or, correlatively, the duty of the health provider to do no harm (*primum non nocere*).

BENEFICENCE, meaning the right of health care consumers to expect the provider to actively pursue measures to secure their welfare; correlatively, the duty of the provider to advocate for the patient's welfare and to assist in realizing that welfare.

JUSTICE, meaning the right of persons to expect fair and just treatment; correlatively, the duty of the health provider to treat patients justly and to provide them what they are owed without prejudice or discrimination.

(Beauchamp and Childress, 1989).

Since this paper deals with the ethical relationship between nurses and their "clients," I will not go into malpractice issues per se. Rather, we shall briefly examine the four quintessential ethical duties that nurses--as well as other health providers--owe their clients.

Although no one would criticize the principles governing patient advocacy as anything less than laudable, ethical dilemmas in medicine occur largely in cases that present conflict among these goals. Thus, the so-called "right-to-die" movement, or controversies over abortion, pit individual autonomy or liberty interests against nonmaleficent and beneficent motives that seek to protect and sustain human life. Ethical problems over diminishing third-party reimbursement pit duties of beneficence--which largely urge that medicine and health care be allocated on the basis of individual need--with justice issues that are driven by principles of fairness and the need for economic stability within health care.

Finding solutions to ethical dilemmas can occur through a variety of strategies, such as referring the matter to an ombudsman, an ethics committee, a policy and procedures committee, or some other third party. However a dilemma is judged, though, ethical or valuative principles will be brought into play and discussed. The best ethical solution, which is not necessarily the one that will emerge of course, will usually be the one that most advances or least compromises the interests of the client's or patient's right to autonomy, nonmaleficence, beneficence, and justice. The difficulty in arriving at such a solution, however, consists in the clashes among the various parties who have a stake in the outcome of the deliberation.

In surveying how ethical problems are understood, it is interesting to observe how the nature and gravity of an ethical problem is significantly influenced by the way one perceives or identifies oneself as a health care provider. Over the last decade, the nursing literature has discussed three models by which nurses construe their professional relationships with patients.

Models of the Nurse-Patient Relationship

Murphy (1984) found that nurses perceive their role in the patient relationship as either that of an institutional advocate, physician advocate, or patient advocate. Each of these roles qualifies the nurse's ethical posture toward her patients and, subsequently, serves as a template for determining "good" nursing practices.

The first of the nursing models on which Murphy comments is the nurse bureaucrat or the nurse *as hospital advocate*. Professional behaviors of the nurse bureaucrat arise from a strong identification with the organization's policies, procedures, and institutional goals. This nurse avoids "making waves" by executing institutional policies to the letter and generally interpreting professional relationships with physicians, administrators, other nurses, patients, patients' families, etc. through the filter of the institution's values and the institution's welfare.

Such nurses appear not to have an ethical value system of their own. Indeed, it is questionable whether they even think in terms of ethics or are conversant with the language of autonomy, nonmaleficence, beneficence, and justice. What is more probable is that the hospital policy and procedures serve as the ethical standards that drive the nurse's valuative decisions. To this nurse, the ultimately persuasive ethical justification for behavior is "Because the hospital requires it."

The second type of nurse relation model noted by Murphy is the nurse as *physician advocate*. Here, the nurse will cultivate and enhance the physician-patient relationship, execute all of the doctor's expectations and orders, and subordinate all other loyalties to the physician's authority. Whereas the nurse bureaucrat justifies conduct by referring to hospital requirements, the nurse as physician advocate justifies behavior as deriving from the doctor's expectations. Consequently, the moral posture of the nurse physician advocate is that of the physician. Like the nurse bureaucrat, the nurse physician advocate does not own a personal system of values. The nurse may, however,--depending on the moral sensitivity of the physician--strongly identify or acknowledge distinct ethical issues. Nevertheless, resolution of these issues will not be self-generated but, rather, will issue from the physician. So, while this nurse may embrace or project a moral attitude, the standards undergirding that attitude will be the physician's, not the nurse's.

The nurse as *patient advocate* is morally superior to the preceding two. The principal reason is that this position begins by acknowledging the patient's rights as morally compelling and proceeds with eliciting and discussing patient choices and decisions. Since one's choices and decisions are immediate expressions of one's self, the nurse patient advocate directly acknowledges and respects her patient's personhood. The other two models fail to do this as they ideologically subordinate or define the patient's interests, concerns, and values to the hospital's policies or the physician's morality. The hospital and physician advocacy models of nursing, therefore, do not allow the patient to <u>be</u> himself or herself through exercising his or her decision-making capacity. Instead, they approach the patient as a mute object or the passive recipient of health services (and someone else's moral decisions). If, however, the ultimate beneficiary of professional services is the consumer, then it is easy to see how the hospital- or physician-based nursing models devalue the consumer by disallowing his or her decisions and choices. To that extent, they are that much less "professional."

. . . the hospital- or physician-based nursing models devalue consumers by disallowing their decisions and choices.

Patient Advocacy and Informed Consent

To appreciate from a practical perspective how the nurse patient advocate represents an ethically superior model, we will examine it through the notion of informed consent. There are two good reasons for such an approach:

1) Informed consent is perhaps the most apparent, formal mechanism for respecting patients' rights and advancing patient advocacy.

2) Nurses report that informed consent dilemmas are the most frequent ones they encounter (Pinch, 1985; Cassels and Redman, 1989).

The objective of informed consent in health care situations is straightforward: If patient autonomy is truly to be respected, then patients need to have an opportunity to make truly informed decisions. Since the health provider is the one who will subject the patient to treatment and its risks, the provider is obviously in the best position to explain the nature of the treatment and those risks to the patient. Additionally, the provider should discuss with the patient what treatment alternatives exist, their various success rates, and outcomes for those alternatives. The provider should explain why the patient needs treatment and what will happen if the patient refuses treatment (Rosoff, 1981; Rozovsky, 1984). In effect, the provider is expected to supply the patient with a reasonable amount of information so that the patient can reflect and evaluate that information and come to an informed decision. Indeed, "informed decision" is perhaps a better term than informed consent since the latter label implies that consent is taken for granted whereas the gist of the informational disclosure signifies the patient's right to refuse the treatment.

Nurses are <u>not</u> primarily responsible for informing patients. Black letter law states that the actual provider of the treatment--who is usually the treating physician--has that ultimate responsibility (Creighton, 1986). Nevertheless, nurses are drawn into informed consent proceedings in at least two ways: Patients frequently ask them to explain aspects of the information or to elaborate on that information, and nurses frequently witness the signing of the consent form.

In witnessing the signing of a consent form, the nurse is legally understood as only that: a witness.

A number of situations may arise that create anxiety for nurses over informed consent. A very common concern among nurses is their legal liability as witness to a patient's signing a consent form. Can the nurse be sued if the form is inadequate, or if the patient has failed to understand a treatment risk that materializes later on?

Although plaintiff lawyers are known for their creativity and imagination in listing causes of action and the identities of defendants in malpractice suits, the general answer to the above questions is <u>no</u> (Greenlaw, 1983). In witnessing the signing of a consent form, for example, the nurse is legally understood as only that: a witness. The law will not hold the nurse liable for the patient's lack of information; the treating physician is responsible for informing patients about treatment alternatives. The more ethically perplexing case is when the patient starts questioning the nurse who, in turn, feels uncomfortable responding to the questions. Perhaps the questions exceed the nurse's understanding (in which case she should not answer) or perhaps she is concerned about the extent to which the patient's physician would feel uncomfortable with her answering (in which case she should call the doctor to discuss this).

Be that as it may, the spirit (rather than the letter) of the informed consent law primarily focuses on the patient having been informed and is only secondarily concerned about the identity of the informant, even though the primary physician is the most likely to be sued in instances of negligence.

Now, consider the following scenario: Suppose Ms. Smith becomes exasperated with the way Dr. Jones routinely but inadequately informs patients about the risks and discomforts of a certain

surgery that he frequently performs. As a result, an inordinate number of Jones' patients subsequently complain to Ms. Smith about being led down a rosy path, wonder if they did the right thing by consenting to that surgery, and criticize Dr. Jones for holding back or misrepresenting information. How ought Ms. Smith respond to the situation? If she perceives herself as a hospital advocate, she might suppress formally complaining about Dr. Jones since she realizes that such complaining is likely to antagonize him as well as other staff who may interpret her complaints as disloyal, disrespectful, insubordinate, arrogant, or unprofessional. If she perceives herself as a physician advocate, she will justify Dr. Jones' manner of communicating to patients as the one that he believes works best. And since she believes that Dr. Jones' version of what works best is the ethical barometer of what is best, she will again withhold criticism.

The nurse as patient advocate, however, will surely be enough impressed by the inadequacies of Dr. Jones' communication style to feel a need to do something about it. Yet, she doubtlessly will be concerned about possible hostile reactions to her advocacy efforts. From an ideal perspective, Ms. Smith ought not only to expect that her facility will provide an organizational channel for her to voice her concerns about Dr. Jones, she also ought to anticipate that her nurse colleagues will support her behavior and actions and will be assertive in protecting Ms. Smith from unjustified organizational hostility. This is the ideal scenario. How will Ms. Smith's efforts actually pan out? Can she anticipate that her comprehension of patient advocacy is shared by her institution and enough of her colleagues so that she can complain about Dr. Jones without fearing unjust recriminations? And what do these questions have to say about nursing curricula?

Patient Advocacy and the Nursing Curriculum

Nurses must be familiar with the ideology of patient advocacy before they can incorporate it into their practice behaviors. This familiarity cannot occur without a certain amount of reflection on and understanding of the ethical environment of medicine and respect for how patients and their rights are incorporated into that environment. Not surprisingly, Felton and Parsons (1987) found that nurses' exposure to ethics courses was a key determinant in the degree of moral sensitivity they registered on formal tests of ethical astuteness and decision making.

Nursing curricula ought, therefore, to insure that student nurses are exposed to the language and theory of ethics as well as to ethical decision-making practice and strategies. Indeed, discussion and analysis of ethics case studies are indispensable elements in nurse ethics courses. The nurse who becomes well versed in formal ethical theories, such as utilitarianism or deontologism, but who is unpracticed in applying that theory to actual cases is like the law school graduate who has yet to try a case. Just as the inexperienced attorney comes to learn that no two cases are exactly alike and that the legal theory that applied to one case may not apply to another, so the complexities of experience and real people bring the principled reflections of intellectual theory into the world of practical affairs (Jonsen, 1991). Thus, while ethical theory may guide and somewhat focus decision making, specific cases may present confounding elements that elude a theoretical "quick fix." The value of case study analyses consists in their forcing us to reflect and clarify the ethical principles and issues that are at stake, and then to decide and be able to justify which principles are most compelling in resolving the dilemma. In so doing, student nurses will find themselves expressing their own value systems--which they may be only been partially or dimly aware of--and having that value system examined by others in the course. This examination may itself lead to deeper insights into ethical practice and assist nurses in refining their own decision-making skills.

Nurses must be familiar with how the language of autonomy, nonmaleficence, beneficence, and justice applies to specific cases.

The ultimate goal of such coursework in ethics, though, is to enable nurses to see themselves as moral agents in the health care setting (Cassells and Redman, 1989). That is, nurses must perceive themselves as ethically responsible individuals who will pursue measures to ensure the moral

propriety of their own and their colleagues' behavior. If the locus of that moral propriety is defined by patient advocacy, however, the nurse as patient advocate must learn to accept the inevitability of taking risks. These risks will occur primarily in confronting behaviors that the nurse finds morally unacceptable and then in dealing with the repercussions of these confrontations, such as might occur in the Dr. Jones case.

As patient advocates, all nurses need support from their nurse colleagues. This support consists of a number of aspects. One is the already discussed intellectual assurance that nurses will speak from a common moral context that includes familiar moral language and vocabulary. Nurses are able to support one another on ethical dilemmas to the extent they agree on moral objectives and are able to understand one another's moral parlance. Another issue is whether a nursing staff will perceive its identity as one of patient advocacy and how that advocacy affects the political context in which health providers function. Thus, discussing whether nurses are hospital advocates, physician advocates, or patient advocates is, in large measure, also a discussion of the nurses' loyalties and the theoretical underpinnings of those loyalties. If one can anticipate that the nurse functioning as patient advocate will inevitably encounter organizational friction--despite the prima facie moral superiority of her patient advocacy--then this nurse ought not be abandoned for her efforts or face any unfavorable consequences of her advocacy (assuming it proceeds with integrity).

. . . corporate loyalty and patient advocacy in nursing ought ideally to advance one and the same set of interests.

Nursing curricula can address the political realities of the nurse in medicine within an ethics course and discuss how certain behaviors can achieve ethically and organizationally satisfying ends. Indeed, one would hope that organizational goals are congruent with ethical ones and that the means with which those goals are pursued can pass ethical scrutiny. Because practical experience shows that a nurse's patient advocacy may clash with certain goals, interests, or the "personality" of a facility or a physician, the ideology of the nurse as patient advocate must be presented as embedded within an organizational context (Aroskar, 1982).

To a much greater extent than physicians, nurses practice within the confines of organizations and bureaucracies. Their behavior, then, is expected to meet the goals of those organizations, which are always multiple, for example, public relations, quality control, personnel management, fiscal solvency, and growth. Because health care organizations, however, are theoretically and ideally committed to the welfare of the consumers of their services and because realizing that welfare frequently involves highly complex and sophisticated procedures, health care organizations must be fundamentally committed to ethical practice. To ignore this ethical mandate would mean subjecting themselves to public indignation and rage by subordinating the welfare of consumers to the welfare of the organization. Moreover, because the professionals who are employed by health organizations must themselves be held to ethical codes of conduct as required by licensing boards and as expected from health care consumers, institutions are commonly held to be responsible for the conduct of employees.

In sum, then, a very practical need exists for health care institutions to be ethical, since extremely serious penalties lie in wait for those that are not. Furthermore, our contemporary social and political climate seems rather impatient and unforgiving of authority figures or institutions that are vested with the public trust and then proceed to ignore or violate that trust.

It seems that however simple and obvious these observations are, nurses must learn to include them in defining their loyalty to the hospital or facility. That is, corporate loyalty and patient advocacy in nursing ought ideally to advance one and the same set of interests. To the extent, however, that those interests consistently go off in distinctly different directions, one might at least entertain the notion that corporate policy and practice may need revision.

For these reasons, nursing curricula ought to include discussion of policies for resolving disputes, perhaps as part of an ethics course. Nurses as well as administrators ought to be impressed with the

need to maintain ethical scrutiny over the provision of services to patients or clients. They ought to be favorably impressed by the nurse who comes forward to direct attention to policy and procedures that she believes are contrary to the interests of consumers. Rather than suspect this nurse as a potential whistleblower or brand her as a complainer, an authentic professional response would carefully examine the merits of her claims and then proceed in an accordingly ethical manner. Nursing curricula ought to convey this moral posture to students.

Students ought to graduate with an impression of how patient advocacy can guide and inform corporate goals, interpersonal styles, and the nursing role. They ought to be able to describe how meaningful and satisfying methods of resolving disputes can be incorporated into organizational policy and practices, and they ought especially to be aware of the importance of collegial support in addressing perceived wrongs and grievances. It is absurd to expect nurses to routinely function as patient advocates if the predictable liability of doing so is organizational censure or dismissal. The theoretical roots of an ethical imperative that ought to be discussed in nurse education programs urge developing a moral "climate" within which the nurse's role as patient advocate can advance not only the patient's interests but the organization's interests as well.

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